stomach is entirely in the chest, the 'gastrostomy' tube is passed retrograde into the stomach through a jejunostomy and via the duodenum).

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Reference

1 McNamee CJ *et al.* A new method of dealing with late presenting spontaneous esophageal ruptures. *Ann Thorac Surg* 1991; 52: 151–3.

A method to facilitate transcystic exploration of the common bile duct at laparoscopic cholecystectomy

The above technique reported by Gould *et al. (Annals,* May 1996, vol 78, p228) uses an intravenous catheter to maintain cystic duct position. Common bile duct exploration at laparoscopic cholecystectomy requires a combination of different techniques to be available to the surgeon as common bile ducts and stones come in a variety of different sizes and combinations! Small ducts and small stones and larger ducts with large or multiple stones require to be approached in different ways. The technique described uses a size 14 Abbocath which, taking the smallest of balloons or baskets, can be extremely frustrating to guide a stone up into the cystic duct.

The laparoscopic cholecystectomist should spend some time with their interventional radiological colleagues where a combination of guidewires, sheaths, balloon and baskets will be found to cover all eventualities. Dilating the cystic duct and positioning a 12G sheath instead of an intravenous catheter can make entry into the cystic duct easier and accessible to the smaller choledochoscopes or ureterorenoscopes and stones can then be removed under direct vision.

When the duct is large and contains multiple stones it is unlikely that the duct will be cleared transcystically. A standard choledochotomy is then the way to go as suggested. However, there is an alternative technique that can be used for large ducts with moderate sized stones *(1)*. The duct can be punctured directly with a spinal needle. After a guidewire has been screened across the papilla into the duodenum, further dilatation and introduction of a 12G sheath allows a balloon sphincteroplasty to be performed easily, after which stones can be pushed into the duodenum. A small diameter choledochoscope can then be used to check the duct via the sheath.

The 12G hole in the common bile duct can then easily be closed using a pursestring suture laparoscopically.

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Reference

1 Singanayagam J, Oxtoby, JW, Varghese J, West DJ, Deakin M. Percutaneous transperitoneal balloon sphincteroplasty during laparoscopic cholecystectomy for choledocholithiasis. *Clin Radiol* 1996; 50: 867–8.

'Emergency room' thoracotomy: is it ever justified?

We read with interest Mr Roxburgh's review of emergency thoracotomy after traumatic penetrating chest injury *(Annals,* July 1996, vol 78, p327) and agree with his general guidelines on the indications and techniques of surgical intervention.

Many patients with penetrating cardiac injury do not reach hospital alive, but for those who do, urgent action is necessary to preserve the patient's life. In these situations there is no substitute for experienced cardiothoracic surgical help and, if available, should be summoned without hesitation. However, many hospitals do not have ready access to these facilities *(1)* and for this reason it is essential for all surgical trainees and emergency medicine specialist to be familiar with the techniques for emergency access to the chest, its indications and possible outcomes.

Though Mr Roxburgh concentrated on penetrating injury which is becoming more prevalent, it is blunt chest injury which more commonly presents to the accident and emergency department.

It is important to realise that the results of emergency room thoracotomy or sternotomy (in more experienced hands) for blunt chest trauma differs from that to be expected in penetrating injury, where a clearly defined potentially remedial injury may be dealt with.

Kavolius *et al. (2)* indicated that immediate thoracotomy in the emergency room carried a 27% survival rate in penetrating chest wounds but only 6% in blunt trauma cases. Dismal survival figures as low as 2% after thoracotomy for blunt injury have also been demonstrated by others *(3)* in units in America and South Africa where surgeons are far more experienced in these interventions than their colleagues in the United Kingdom. Not unsurprisingly, blunt trauma patients arriving in asystole had the worst chances of survival

The surgeon embarking on such heroic surgery in the accident department after non-penetrating injury should be aware that his efforts are more likely to be in vain under these circumstances.

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2 Kavolius J, Golovsky M, Champion HR. Predictors of outcome in patients who have sustained trauma and who undergo emergency thoracotomy. *Arch Surg* 1993; **128**: 1158–62.

3 Lorenz HP, Steinmetz B, Lieberman J *et al.* Emergency thoracotomy: survival correlates with physiologic status. *J Trauma* 1992; **32**: 780–5.

Audit of 149 consecutive carotid endarterectomies performed by a single surgeon in a district general hospital over a 12-year period

The authors of this paper *(Annals,* July 1996, vol 78, p340) report an increased incidence of carotid artery surgery since the publication of the two large randomised controlled trials, and a major stroke rate of 5.7%. The